

PEDIATRIC ASYSTOLE PULSELESS ELECTRICAL ACTIVITY

HPI	Signs & Symptoms	Possible Causes	
<ul style="list-style-type: none"> Witnessed vs unwitnessed Last known well PTA AED use Bystander CPR Suspected etiology PMH 	<ul style="list-style-type: none"> Pulseless Apneic No signs of rigor or lividity No findings of signs incompatible with life 	<ul style="list-style-type: none"> Hypovolemia Hypoxia Acidosis Hyper/o-kalemia Hypothermia Hypoglycemia 	<ul style="list-style-type: none"> Toxins/OD Cardiac tamponade Acute coronary syndrome Pulmonary embolism Trauma Tension Pneumo

UNIVERSAL EMERGENCY CARDIAC CARE

	EMR	EMT	PM
1. Assess responsiveness, pulse and breathing for no more than 10 seconds.	•	•	•
2. Consider and treat reversible causes of arrest	•	•	•
3. If no pulse and not breathing/gasping - Begin 2-rescuer CPR 15:2 compressions to ventilations for a 2 min. cycle	•	•	•
4. Ventilate with BVM on 100% OXYGEN with airway adjuncts, 1 breath every 2-3 sec.	•	•	•
5. Monitor Capnography.		•	•
6. Place monitor/defibrillator immediately as staffing allows	•	•	•
7. Analyze rhythm and continue CPR 2 min.			•
8. Obtain vascular access IV/IO			•
9. Consider advanced airway: ETT			•
or i-Gel.		•	•
Monitor placement with Capnography. Deliver 1 breath/6 sec.			

PERSISTENT NON-SHOCKABLE

10. Analyze rhythm. Continue CPR 2 min.			•
11. EPINEPHRINE 1 mg/10mL: 0.01 mg/kg IVP/IO, max. single dose 1 mg, repeat 3-5min., no max.			•
12. NORMAL SALINE in 20 mL/kg, may repeat			•
13. If return of spontaneous circulation see ROSC	•	•	•

NOTE:

- Utilize [High Performance CPR](#) for best patient outcome.
- The best airway is an effective airway with the least potential complications.

Use Calculator for dosing